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Appendix 1:
2013-2016 Tables

Table 1. Number of HIV Tests Conducted by Federal Agencies in 2013

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,352,513	29,003	0.87%	21,712	74.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,331,210	DNC[e]	UA[f]	DNC	UA
Medicare	262,321	DNC	UA	DNC	UA
Health Resources and Services Administration (HRSA)					
HAB[g]	787,663	8,654	1.10%	7,774	89.83%
BPHC[h]	1,188,651	DNC	UA	DNC	UA
Indian Health Service (IHS)					
IHS/Tribal/Urban	51,535	87	0.17%	6	6.90%
Office of Population Affairs (OPA)					
Routine Services -95 Title X Service Grantees & Independent Grant Awards	1,371,181	2,121	0.15%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	39,519	DNC	UA	DNC	UA
CSAT TCE[j]	16,607	184	1.11%	112	60.87%
Department of Veterans Affairs (VA)					
	505,830	1,793	0.35%	DNC	UA
Total Number of Tests: 9,817,020					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2010 is presented in the 2013 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services."

Table 2. Number of HIV Tests Conducted by Federal Agencies in 2014

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,198,430	28,420	0.89%	21,843	76.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,403,423	DNC[e]	UA[f]	DNC	UA
Medicare	219,948	DNC	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	58,076	322	0.55%	319	99.07%
Health Resources and Services Administration (HRSA)					
HAB[g]	802,440	7,575	0.94%	6,798	89.74%
BPHC[h]	1,322,317	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	96,602	111	0.11%	DNC	UA
Office of Population Affairs (OPA)					
	1,031,624	2,112	0.20%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	17,426	DNC	UA	DNC	UA
CSAT TCE[j]	10,530	81	0.77%	DNC	UA
Department of Veterans Affairs (VA)					
	319,999	665	0.21%	DNC	UA
Total Number of Tests: 9,480,815					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2012 is presented in the 2014 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services.

Table 3. Number of HIV Tests Conducted by Federal Agencies in 2015

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,038,074	27,729	0.91%	22,906	82.61%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	237,244	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,420	293	0.48%	291	99.32%
Health Resources and Services Administration (HRSA)					
HAB[g]	652,207	7,009	1.07%	5,936	84.69%
BPHC[h]	1,447,628	DNC	UA	DNC	DNC
Indian Health Service (IHS)					
	91,464	112	0.12%	DNC	DNC
Office of Population Affairs (OPA)					
	1,113,635	2,423	0.22%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	27,731	256	0.92%	199	77.73%
CSAT TCE[j]	8,892	57	0.64%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	4,575	31	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,635	488	0.18%	DNC	UA
Total Number of Tests: 6,953,505					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers.

Table 4. Number of HIV Tests Conducted by Federal Agencies in 2016

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,035,128	27,373	0.90%	21,451	78.36%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	236,571	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,671	203	0.33%	203	100%
Health Resources and Services Administration (HRSA)					
HAB[g]	563,400	5,826	1.03%	5,118	87.85%
BPHC[h]	1,612,535	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	85,772	131	0.15%	DNC	UA
Office of Population Affairs (OPA)					
	1,163,883	2,824	0.24%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	23,280	189	0.81%	DNC	UA
CSAT TCE[j]	9,475	49	0.52%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	7,452	51	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,575	476	0.18%	DNC	UA
Total Number of Tests: 7,069,742					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers

Department of Health and Human Services

Centers for Disease Control and Prevention

Report to Congress

Regarding

National HIV Testing Goal

Robert R. Redfield, MD

Director

Centers for Disease Control and Prevention

Department of Health and Human Services

DATE 2019

Executive Summary

In 2009, as part of the Ryan White HIV/AIDS Treatment Extension Act, Congress directed the Secretary of the Department of Health and Human Services (HHS) to establish an annual HIV testing goal of 5,000,000 tests for federally supported HIV and AIDS prevention, treatment, and care programs. This report includes data from HHS agencies, the Department of Veterans Affairs, and the Federal Bureau of Prisons. In 2016[1], the federal agencies contributing to this report surpassed the national HIV testing goal by conducting 7,069,742 tests.

While federal agencies reported a number of barriers to achieving optimal HIV testing and linkage or referral to care rates, those barriers did not preclude agencies' successful attainment of the national HIV testing goal. Instead, these barriers placed limits on the extent to which agencies could exceed the testing goal and fully measure their progress toward reaching the goal. Federal agencies are actively taking steps to remove or mitigate these barriers to succeed in achieving optimal levels of HIV testing, referrals, and linkage to care.

Using published estimates of the cost of conducting an HIV test in health care and non-health care settings, as well as data from contributing federal agencies, the Centers for Disease Control and Prevention (CDC) estimates the cost of reaching the annual goal of conducting five million HIV tests at approximately $1.24 billion in 2017 U.S. dollars. Importantly, in its review of the published literature on the cost-effectiveness of HIV testing, CDC continues to find strong evidence that not only is HIV testing cost-effective (i.e., testing benefits outweigh testing costs), but it also may be cost-saving (i.e., testing benefits, such as earlier linkage to treatment, even considering the costs, actually save money).

[1] The last report was submitted in 2013 and included 2012 data. This report includes data from 2013 through 2016. 2016 data is under-reported as certain agencies have a delay in data collection. The actual number of tests conducted is therefore higher than the 7 million figure that is reported.

The HHS Secretary is dedicated to ensuring that federal agencies continue to meet and surpass the national HIV testing goal every year.

Purpose

In the Ryan White HIV/AIDS Treatment Extension Act of 2009, Congress added the following requirement:

"a) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a national HIV/AIDS testing goal of 5,000,000 tests for HIV/AIDS annually through federally-supported HIV/AIDS prevention, treatment, and care programs, including programs under this title and other programs administered by the Centers for Disease Control and Prevention"

"(b) ANNUAL REPORT.—Not later than January 1, 2011, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to Congress a report describing, with regard to the preceding 12-month reporting period--

'(1) whether the testing goal described in subsection (a) has been met;

'(2) the total number of individuals tested through federally-supported and other HIV/AIDS prevention, treatment, and care programs in each State;

'(3) the number of individuals who--

'(A) prior to such 12-month period, were unaware of their HIV status; and

'(B) through federally-supported and other HIV/AIDS prevention, treatment, and care programs, were diagnosed and referred into treatment and care during such period;

'(4) any barriers, including State laws and regulations, that the Secretary determines to be a barrier to meeting the testing goal described in subsection (a);

'(5) the amount of funding the Secretary determines necessary to meet the annual testing goal in the following 12 months and the amount of Federal funding expended to meet the testing goal in the prior 12-month period; and

'(6) the most cost-effective strategies for identifying and diagnosing individuals who were unaware of their HIV status, including voluntary testing with pre-test counseling, routine screening including opt-out testing, partner counseling and referral services, and mass media campaigns." (Public Law 111-87, Section 2688).

The following report has been prepared by the Departments of Health and Human Services (HHS) and Veterans Affairs (VA) in response to these requirements.

Background

The Centers for Disease Control and Prevention (CDC) estimates that in the United States more than 1.1 million adults and adolescents are living with HIV[2] and approximately over 38,000 people receive a diagnosis of HIV each year (CDC, 2017; CDC, 2018). Almost 1 in 7 persons were unaware that they were living with HIV in the year prior to diagnosis (CDC, 2018).

Currently, populations such as gay, bisexual, and other men who have sex with men (MSM), transgender persons, Blacks/African Americans, Hispanics/Latinos, and people who live in the southern United States, are disproportionately affected by HIV. Moreover, many of the populations most affected by HIV are also those most often unaware of their infection (CDC, 2018). In addition, fewer people with HIV in the South are aware of their infection than in any other region (CDC, 2016a). Consequently, fewer people in the South who are living with HIV receive timely medical care or treatment and a disproportionate number are missing out on the opportunity to preserve their health and avoid transmitting HIV to their partners (CDC, 2016b). While annual HIV infections decreased by 8 percent among the US population from 2010 to 2015, progress remains uneven (CDC, 2018). For example, annual infections remained stable among all MSM but increased by 22 percent among 25-34 year old Hispanic/Latino MSM (CDC, 2018).

[2] Persons with HIV (PWH) is the term utilized by the Division of HIV and AIDS Prevention (DHAP) at the CDC.

The U.S. National HIV/AIDS Strategy: Updated to 2020 (NHAS) guided the federal response to the HIV and AIDS trends, including the testing programs and initiatives implemented by the federal organizations contributing to this report (NHAS, 2015). In addition, the updated NHAS reflects advances in HIV testing technologies and changes in federal, state, and local laws and policies that govern HIV testing and improve the accuracy and availability of HIV testing.

HIV testing provides a critical pathway to prevention and treatment services that prolong the lives of persons with HIV and helps stop the spread of HIV in communities across the United States. Persons with undiagnosed HIV, or with HIV diagnosed late in the course of their infection, miss crucial opportunities to seek care that may prolong and improve the quality of their lives. HIV treatment has dramatically improved the health, quality of life, and life expectancy of people with HIV. Research shows that when people know they are infected with HIV, they take steps to prevent transmission to others (Weinhardt LS et al., 1999). People with HIV who take HIV medicine as prescribed and achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners (Cohen MS, Chen YQ, McCauley M, et al., 2016). Thus, testing provides the crucial first step to maintaining health and preventing transmission.

In recent years, there have been numerous positive advances in both testing technologies and the technologies that promote it (e.g., social media). Advances in testing technology make it possible to more efficiently and effectively determine an individual's HIV status. For example, newer fourth-generation diagnostic tests make it possible to detect HIV soon after infection and at a lower cost. (Chavez et al., 2011; Masciotra et al., 2011). Also, the proliferation and use of social media platforms and new smartphone applications provide new opportunities to reach many persons at risk for acquiring HIV with important HIV prevention information and messages and to promote testing so they know

their status. HIV testing efforts are critical for diagnosing infections and remain a priority for the Federal Government.

Annual National HIV Test Goals for the United States

The annual national HIV testing goal of 5 million tests, established by the HHS Secretary as required by the Ryan White HIV/AIDS Treatment Extension Act of 2009, was surpassed in 2013, 2014, 2015, and 2016 (Appendix 1, Tables 1-4). Federally-supported programs contributing to this report conducted 7,069,742 tests[3] in 2016, thereby substantially exceeding the national goal of 5 million tests. From the available data, 37,122 tests were reported to be positive for HIV, yielding a positivity rate (i.e., the number of positive diagnoses divided by the number of individuals tested) of 0.71 percent[4]. Importantly, 26,772[5] of the individuals were referred to care, treatment, and prevention services (Appendix 1, Table 4).

The Department of Veterans Affairs and two HHS agencies—CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA)– are the only federal organizations that provided data distinguishing between the number of persons testing positive for HIV and the number of persons newly diagnosed with HIV through some of their programs. In 2016, these organizations identified 27,949 individuals infected with HIV, roughly half of whom (12,032 or 43 percent) were not previously diagnosed with HIV.[6] These new diagnoses represent nearly one third of all new diagnoses reported in

[3] Testing data were provided by the VA, the Federal Bureau of Prisons, and the following five agencies and one office of HHS: CDC, Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS), Indian Health Service (IHS), and Office of Population Affairs (OPA). The total number of tests in 2016 is under-reported due to a delay in data collection systems.
[4] (Number of Positive Tests/Number of Tests) x 100. Denominator includes only data from agencies or programs that reported both variables used in the calculation. The rate reported here does not include all federally supported HIV prevention, care, and treatment programs because data on the number of positive diagnoses were not available from all programs.
[5] Note that several agencies with large testing volumes (most notably, CDC) measure linkage to care, rather than referrals, and therefore underestimates federal agencies' performance referring persons who tested positive for HIV to medical care and treatment.
[6] These numbers only include data from those programs that were able to collect information on whether a positive test result represented a new diagnosis of HIV.

2016 in the United States. The federal agencies contributing to this report continue to invest in activities that will better position them to improve their performance in detecting newly diagnosed cases.

The HIV testing data reported by the contributing federal organizations are subject to a number of caveats that are discussed in the next section of this report. These organizations recognize the need to take steps to ensure that future data collection systems meet the specific operational needs of their organizations and allow for accurate cross-agency assessments of the federal government's response to national HIV trends.

Limitations to HIV Testing Data

The data presented in this report are subject to limitations related to data collection, data comparability, synthesis, and interpretation. The previous Testing Report to Congress described in detail the limitations found when compiling and analyzing the relevant testing data; many of these limitations remained in 2016.

Data collection continues to be a challenge due to the nature of the health care system and the individual organizations collecting data. Parts of the system are oriented toward documenting outputs (e.g., number of HIV tests) rather than outcomes (e.g., a positive or negative HIV test result) because often billing and reimbursement, not public health, was the primary concern driving their design. Data sharing issues and lags in data reporting contribute to challenges in ensuring data are standardized, accurate, and complete.

Data limitations also stem from cross-agency (and, in many cases, cross-program and cross-grantee) variance in 1) the definitions applied to primary data elements, and 2) the independence of the systems used to manage and generate these data. In particular, two data points, "number of tests" and "number of new positives," exemplify both these limitations and their ramifications for measuring the cumulative impact of federally-funded HIV testing activities. Some agencies reported the total number of HIV

tests[7] conducted, while others reported the number of test events.[8] Similarly, among those agencies that reported the number of persons with HIV newly diagnosed through their programs, some relied entirely on client self-reports of not having a previously diagnosed HIV infection, while others confirmed such reports with HIV surveillance data collected by health departments. Further, because federal agencies do not collect, maintain, or share personally identifiable information (e.g., the names and birthdates of persons who test positive for HIV), matching and avoiding duplication of data across systems at the federal level is not possible.

Barriers to Achieve Optimal Levels of Testing

While the annual testing goal of five million tests was again surpassed in 2016, contributing federal organizations continue to experience barriers to achieving even higher levels of HIV testing and, specifically, identifying persons with undiagnosed HIV. Federal agencies identified barriers encountered by agencies, grantees, and testing providers, including data collection and coordination, funding, staffing, and policies.

- *Data Collection* -- Many agencies, grantees, and providers have challenges collecting and reporting data. These issues are generally related to the following:
    - **Training**: Agencies are challenged by lack of staff knowledge of data management in both storing and analyzing data collected.
    - **Data collection tools and software:** Agency data infrastructure often does not fully support efficient use of Electronic Health Records (EHR).

[7] Preliminary and confirmatory HIV tests were counted independently. Accordingly, when an individual whose preliminary test was positive received a confirmatory test, his or her two tests would both be counted towards the total number of tests reported.

[8] A testing event could include up to three tests for a given individual when these tests were conducted as part of a single testing episode. For example, person who tests positive on a preliminary HIV test and so receives a confirmatory test would be captured as one testing event.

- **Coordinating across large and disperse facilities:** Some agencies have regional facilities that use private sector EHR platforms that are not linked to the public EHR platform.

- *Funding* -- For some agencies, limited and uncertain funding challenges their ability to design and implement high-impact HIV prevention strategies.
  - **No base funding:** Some agencies receive no base funding for HIV-related activities and are dependent on annual proposals to Minority HIV/AIDS Fund to support their testing efforts.
- *Staffing* -- High rates of staff turnover for grantees, hiring freezes, and limited access to quality training can delay program implementation and reduce effectiveness of testing activities.
  - **Staff Turnover and New Staff**: Constantly educating and training a high proportion of new staff slows down program implementation.
  - **Hiring Freezes**: Some states implement hiring freezes that even apply to federally granted funds.
- *Laws, Regulations, and Organizational Policies* - Several organizations expressed the need for clarification on various HIV testing policies and regulations.
  - **Limited knowledge of existing regulations:** Some agencies were unaware of what regulations were in place surrounding rapid testing without laboratory technicians.
  - **Difficulty instituting programs given existing laws:** Some grantee programs found it difficult to institute an opt-out testing model as several states require written informed consent for HIV testing.

Cost Estimate to Conduct Five Million Tests

CDC estimated the median cost of reaching the annual goal of conducting 5 million HIV tests was $1.24 billion (range: $0.62B to $1.86B) in 2017. Federal organizations published costs and cost data from

evaluation studies of HIV testing programs. These data vary substantially based on testing settings, testing strategies, testing technologies, inclusion or exclusion of linkage to care, assumptions, and costing methods. Based on the range of cost estimates available in the literature and their relative alignment with the range of figures reported by federal agencies for this report, CDC used a potential median cost of $80 per test in clinical settings and $750 per test ($US 2017) in non-clinical settings to arrive at a cost estimate (Shrestha *et al.* 2008, 2011, 2012). To estimate the lower and upper bounds for the federal funding needed to meet the annual testing goal, CDC then varied the median cost estimates by 50 percent in either direction.

Cost-Effectiveness of HIV Testing

The previous Testing Report to Congress described CDC's systematic review of the cost-effectiveness literature relevant to HIV testing and, where possible, compared the costs and effects of different HIV testing. The literature used several cost-effectiveness measures: cost per quality adjusted life year (QALY) saved, cost per life year (LY) saved, cost per HIV infection averted, and cost per new HIV diagnosis identified. Variation across studies limited CDC's ability to directly compare results across different testing approaches or implementation settings. Additional details can be found on pages 29-37 in the previous report.

The value to the nation of attaining the goal of conducting 5 million HIV tests will, however, far outweigh the initial federal investment needed to meet it. A review of the literature continues to show that voluntary HIV testing is cost-effective, and potentially even cost saving,[9] across a wide range of implementation scenarios and settings (Lin *et al.*, 2016; Hutchinson *et al.*, 2016; Schackman *et al.*, 2015; Farnham *et al.*, 2012; Lucas and Armbruster, 2012; Long *et al.*, 2010; Paltiel *et al.*, 2006; Paltiel *et al.*, 2005; Sanders *et al.*, 2005; Walensky *et al.*, 2005). CDC identified one published study that

[9] "Cost-saving" indicates that the money spent to deliver the service was less than the money saved by avoiding downstream costs (e.g., the lifetime treatment costs associated with those HIV infections that would have otherwise have been acquired).

estimated the return on investment (ROI) associated with CDC's own Expanded Testing Initiative (ETI) to be $1.95 back to the health care system as a whole, for each dollar invested. When disregarding the downstream treatment costs associated with earlier awareness of HIV infection, the ROI rose to $11.43. Since many medical interventions have negative (i.e., less than $1) ROIs (Trogdon *et al.*, 2009), these findings suggest that large scale, HIV testing programs like CDC's ETI yielded strong economic and public health returns (Hutchinson *et al.*, 2012).

Conclusion

Federal agencies will continue to play an important role in ensuring that HIV testing services are available to those individuals not optimally reached through the private sector. As part of the *Ending the HIV Epidemic: A Plan for America* initiative, CDC will work closely with other HHS agencies, local, and state governments, communities, and people with HIV to coordinate efforts to increase capacity to test for and diagnose all people with HIV as early as possible. Agencies will also continue to explore better ways to assist states, health care providers, community based organizations (CBOs), and other funded entities to address the challenges and barriers they encounter when providing HIV testing services. Although federally supported HIV prevention, care, and treatment programs have substantially exceeded the annual national HIV testing goal, there is still more work to be done to increase the proportion of persons whose infections are diagnosed, and where possible, diagnose them early. Federal agencies continue to be committed to focusing efforts on increased HIV testing as a bridge to improved health and well-being of individuals with HIV and in the communities in which they live.

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Appendix 1:
2013-2016 Tables

Table 1. Number of HIV Tests Conducted by Federal Agencies in 2013

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,352,513	29,003	0.87%	21,712	74.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,331,210	DNC[e]	UA[f]	DNC	UA
Medicare	262,321	DNC	UA	DNC	UA
Health Resources and Services Administration (HRSA)					
HAB[g]	787,663	8,654	1.10%	7,774	89.83%
BPHC[h]	1,188,651	DNC	UA	DNC	UA
Indian Health Service (IHS)					
IHS/Tribal/Urban	51,535	87	0.17%	6	6.90%
Office of Population Affairs (OPA)					
Routine Services -95 Title X Service Grantees & Independent Grant Awards	1,371,181	2,121	0.15%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	39,519	DNC	UA	DNC	UA
CSAT TCE[j]	16,607	184	1.11%	112	60.87%
Department of Veterans Affairs (VA)					
	505,830	1,793	0.35%	DNC	UA
Total Number of Tests: 9,817,020					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2010 is presented in the 2013 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services."

Table 2. Number of HIV Tests Conducted by Federal Agencies in 2014

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,198,430	28,420	0.89%	21,843	76.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,403,423	DNC[e]	UA[f]	DNC	UA
Medicare	219,948	DNC	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	58,076	322	0.55%	319	99.07%
Health Resources and Services Administration (HRSA)					
HAB[g]	802,440	7,575	0.94%	6,798	89.74%
BPHC[h]	1,322,317	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	96,602	111	0.11%	DNC	UA
Office of Population Affairs (OPA)					
	1,031,624	2,112	0.20%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	17,426	DNC	UA	DNC	UA
CSAT TCE[j]	10,530	81	0.77%	DNC	UA
Department of Veterans Affairs (VA)					
	319,999	665	0.21%	DNC	UA
Total Number of Tests: 9,480,815					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2012 is presented in the 2014 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services.

Table 3. Number of HIV Tests Conducted by Federal Agencies in 2015

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,038,074	27,729	0.91%	22,906	82.61%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	237,244	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,420	293	0.48%	291	99.32%
Health Resources and Services Administration (HRSA)					
HAB[g]	652,207	7,009	1.07%	5,936	84.69%
BPHC[h]	1,447,628	DNC	UA	DNC	DNC
Indian Health Service (IHS)					
	91,464	112	0.12%	DNC	DNC
Office of Population Affairs (OPA)					
	1,113,635	2,423	0.22%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	27,731	256	0.92%	199	77.73%
CSAT TCE[j]	8,892	57	0.64%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	4,575	31	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,635	488	0.18%	DNC	UA
Total Number of Tests: 6,953,505					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers.

Table 4. Number of HIV Tests Conducted by Federal Agencies in 2016

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,035,128	27,373	0.90%	21,451	78.36%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	236,571	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,671	203	0.33%	203	100%
Health Resources and Services Administration (HRSA)					
HAB[g]	563,400	5,826	1.03%	5,118	87.85%
BPHC[h]	1,612,535	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	85,772	131	0.15%	DNC	UA
Office of Population Affairs (OPA)					
	1,163,883	2,824	0.24%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	23,280	189	0.81%	DNC	UA
CSAT TCE[j]	9,475	49	0.52%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	7,452	51	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,575	476	0.18%	DNC	UA
Total Number of Tests: 7,069,742					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers

VAExecSec

From: VAExecSec
Sent: Monday, August 19, 2019 3:54 PM
To: VHA CO 10B1 Correspondence Mgmt. Staff; VHA CO 10B1 Review Staff
Cc: (b)(6) McVicker, Carrie A.; (b)(6)
Subject: FW: For review by 8/21: Report to Congress on National HIV Testing Goals
Attachments: R2 HIV Reporting RTC - CDC rewrite - clean (1).docx

NOTE: There was a system error and EXECSEC rec'd email on today. Prevolia will reach out to HHS to request an extension

Assigned to VHA/ for SECVA sig or appropriate sig level
DUE to EXECSEC by COB on 8/21
FAST TURNAROUND
NOTE: Please email (b)(6) when edits has been uploaded in VIEWS and (001B) will email to HHS

Thanks

(b)(6)
202-461-(b)(6)

From: H(b)(6) (HHS/IOS) <(b)(6)@hhs.gov>
Sent: Wednesday, August 14, 2019 3:00 PM
To: VAExecSec <VAExecSec@va.gov>; DOJExecSec (JMD) <DOJExecSec@usdoj.gov>
Subject: [EXTERNAL] For review by 8/21: Report to Congress on National HIV Testing Goals

Good afternoon –

Please find attached for VA and DOJ review/information the attached *draft* Report to Congress on National HIV Testing Goals, as required by the Ryan White HIV/AIDS Treatment Extension Act of 2009. CDC prepared this report to Congress in cooperation with other agencies in the Department of Health and Human Services, the Department of Justice, and the Department of Veterans Affairs. HHS is now finalizing the internal clearance of this report, and wanted to make sure that VA and DOJ/Federal Bureau of Prisons have a chance to review the report for accuracy regarding language and data specific to VA and DOJ.

Can you please let me know if you have any edits by COB next Wednesday 8/21? I will plan to move forward with the report at that time.

Thank you!

(b)(6)

(b)(6)
Policy Coordinator
Immediate Office of the Secretary, Executive Secretariat
U.S. Department of Health & Human Services
Room 629H, Humphrey Building

Phone: 202-690-(b)(6)

Department of Health and Human Services

Centers for Disease Control and Prevention

Report to Congress

Regarding

National HIV Testing Goal

Robert R. Redfield, MD

Director

Centers for Disease Control and Prevention

Department of Health and Human Services

DATE 2019

Executive Summary

In 2009, as part of the Ryan White HIV/AIDS Treatment Extension Act, Congress directed the Secretary of the Department of Health and Human Services (HHS) to establish an annual HIV testing goal of 5,000,000 tests for federally supported HIV and AIDS prevention, treatment, and care programs. This report includes data from HHS agencies, the Department of Veterans Affairs, and the Federal Bureau of Prisons. In 2016[1], the federal agencies contributing to this report surpassed the national HIV testing goal by conducting 7,069,742 tests.

While federal agencies reported a number of barriers to achieving optimal HIV testing and linkage or referral to care rates, those barriers did not preclude agencies' successful attainment of the national HIV testing goal. Instead, these barriers placed limits on the extent to which agencies could exceed the testing goal and fully measure their progress toward reaching the goal. Federal agencies are actively taking steps to remove or mitigate these barriers to succeed in achieving optimal levels of HIV testing, referrals, and linkage to care.

Using published estimates of the cost of conducting an HIV test in health care and non-health care settings, as well as data from contributing federal agencies, the Centers for Disease Control and Prevention (CDC) estimates the cost of reaching the annual goal of conducting five million HIV tests at approximately $1.24 billion in 2017 U.S. dollars. Importantly, in its review of the published literature on the cost-effectiveness of HIV testing, CDC continues to find strong evidence that not only is HIV testing cost-effective (i.e., testing benefits outweigh testing costs), but it also may be cost-saving (i.e., testing benefits, such as earlier linkage to treatment, even considering the costs, actually save money).

[1] The last report was submitted in 2013 and included 2012 data. This report includes data from 2013 through 2016. 2016 data is under-reported as certain agencies have a delay in data collection. The actual number of tests conducted is therefore higher than the 7 million figure that is reported.

The HHS Secretary is dedicated to ensuring that federal agencies continue to meet and surpass the national HIV testing goal every year.

Purpose

In the Ryan White HIV/AIDS Treatment Extension Act of 2009, Congress added the following requirement:

"a) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a national HIV/AIDS testing goal of 5,000,000 tests for HIV/AIDS annually through federally-supported HIV/AIDS prevention, treatment, and care programs, including programs under this title and other programs administered by the Centers for Disease Control and Prevention"

"(b) ANNUAL REPORT.—Not later than January 1, 2011, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to Congress a report describing, with regard to the preceding 12-month reporting period--

'(1) whether the testing goal described in subsection (a) has been met;

'(2) the total number of individuals tested through federally-supported and other HIV/AIDS prevention, treatment, and care programs in each State;

'(3) the number of individuals who--

'(A) prior to such 12-month period, were unaware of their HIV status; and

'(B) through federally-supported and other HIV/AIDS prevention, treatment, and care programs, were diagnosed and referred into treatment and care during such period;

'(4) any barriers, including State laws and regulations, that the Secretary determines to be a barrier to meeting the testing goal described in subsection (a);

'(5) the amount of funding the Secretary determines necessary to meet the annual testing goal in the following 12 months and the amount of Federal funding expended to meet the testing goal in the prior 12-month period; and

'(6) the most cost-effective strategies for identifying and diagnosing individuals who were unaware of their HIV status, including voluntary testing with pre-test counseling, routine screening including opt-out testing, partner counseling and referral services, and mass media campaigns." (Public Law 111-87, Section 2688).

The following report has been prepared by the Departments of Health and Human Services (HHS) and Veterans Affairs (VA) in response to these requirements.

Background

The Centers for Disease Control and Prevention (CDC) estimates that in the United States more than 1.1 million adults and adolescents are living with HIV[2] and approximately over 38,000 people receive a diagnosis of HIV each year (CDC, 2017; CDC, 2018). Almost 1 in 7 persons were unaware that they were living with HIV in the year prior to diagnosis (CDC, 2018).

Currently, populations such as gay, bisexual, and other men who have sex with men (MSM), transgender persons, Blacks/African Americans, Hispanics/Latinos, and people who live in the southern United States, are disproportionately affected by HIV. Moreover, many of the populations most affected by HIV are also those most often unaware of their infection (CDC, 2018). In addition, fewer people with HIV in the South are aware of their infection than in any other region (CDC, 2016a). Consequently, fewer people in the South who are living with HIV receive timely medical care or treatment and a disproportionate number are missing out on the opportunity to preserve their health and avoid transmitting HIV to their partners (CDC, 2016b). While annual HIV infections decreased by 8 percent among the US population from 2010 to 2015, progress remains uneven (CDC, 2018). For example, annual infections remained stable among all MSM but increased by 22 percent among 25-34 year old Hispanic/Latino MSM (CDC, 2018).

[2] Persons with HIV (PWH) is the term utilized by the Division of HIV and AIDS Prevention (DHAP) at the CDC.

The U.S. National HIV/AIDS Strategy: Updated to 2020 (NHAS) guided the federal response to the HIV and AIDS trends, including the testing programs and initiatives implemented by the federal organizations contributing to this report (NHAS, 2015). In addition, the updated NHAS reflects advances in HIV testing technologies and changes in federal, state, and local laws and policies that govern HIV testing and improve the accuracy and availability of HIV testing.

HIV testing provides a critical pathway to prevention and treatment services that prolong the lives of persons with HIV and helps stop the spread of HIV in communities across the United States. Persons with undiagnosed HIV, or with HIV diagnosed late in the course of their infection, miss crucial opportunities to seek care that may prolong and improve the quality of their lives. HIV treatment has dramatically improved the health, quality of life, and life expectancy of people with HIV. Research shows that when people know they are infected with HIV, they take steps to prevent transmission to others (Weinhardt LS et al., 1999). People with HIV who take HIV medicine as prescribed and achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners (Cohen MS, Chen YQ, McCauley M, et al., 2016). Thus, testing provides the crucial first step to maintaining health and preventing transmission.

In recent years, there have been numerous positive advances in both testing technologies and the technologies that promote it (e.g., social media). Advances in testing technology make it possible to more efficiently and effectively determine an individual's HIV status. For example, newer fourth-generation diagnostic tests make it possible to detect HIV soon after infection and at a lower cost. (Chavez et al., 2011; Masciotra et al., 2011). Also, the proliferation and use of social media platforms and new smartphone applications provide new opportunities to reach many persons at risk for acquiring HIV with important HIV prevention information and messages and to promote testing so they know

their status. HIV testing efforts are critical for diagnosing infections and remain a priority for the Federal Government.

Annual National HIV Test Goals for the United States

The annual national HIV testing goal of 5 million tests, established by the HHS Secretary as required by the Ryan White HIV/AIDS Treatment Extension Act of 2009, was surpassed in 2013, 2014, 2015, and 2016 (Appendix 1, Tables 1-4). Federally-supported programs contributing to this report conducted 7,069,742 tests[3] in 2016, thereby substantially exceeding the national goal of 5 million tests. From the available data, 37,122 tests were reported to be positive for HIV, yielding a positivity rate (i.e., the number of positive diagnoses divided by the number of individuals tested) of 0.71 percent[4]. Importantly, 26,772[5] of the individuals were referred to care, treatment, and prevention services (Appendix 1, Table 4).

The Department of Veterans Affairs and two HHS agencies—CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA)– are the only federal organizations that provided data distinguishing between the number of persons testing positive for HIV and the number of persons newly diagnosed with HIV through some of their programs. In 2016, these organizations identified 27,949 individuals infected with HIV, roughly half of whom (12,032 or 43 percent) were not previously diagnosed with HIV.[6] These new diagnoses represent nearly one third of all new diagnoses reported in

[3] Testing data were provided by the VA, the Federal Bureau of Prisons, and the following five agencies and one office of HHS: CDC, Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS), Indian Health Service (IHS), and Office of Population Affairs (OPA). The total number of tests in 2016 is under-reported due to a delay in data collection systems.
[4] (Number of Positive Tests/Number of Tests) x 100. Denominator includes only data from agencies or programs that reported both variables used in the calculation. The rate reported here does not include all federally supported HIV prevention, care, and treatment programs because data on the number of positive diagnoses were not available from all programs.
[5] Note that several agencies with large testing volumes (most notably, CDC) measure linkage to care, rather than referrals, and therefore underestimates federal agencies' performance referring persons who tested positive for HIV to medical care and treatment.
[6] These numbers only include data from those programs that were able to collect information on whether a positive test result represented a new diagnosis of HIV.

2016 in the United States. The federal agencies contributing to this report continue to invest in activities that will better position them to improve their performance in detecting newly diagnosed cases.

The HIV testing data reported by the contributing federal organizations are subject to a number of caveats that are discussed in the next section of this report. These organizations recognize the need to take steps to ensure that future data collection systems meet the specific operational needs of their organizations and allow for accurate cross-agency assessments of the federal government's response to national HIV trends.

Limitations to HIV Testing Data

The data presented in this report are subject to limitations related to data collection, data comparability, synthesis, and interpretation. The previous Testing Report to Congress described in detail the limitations found when compiling and analyzing the relevant testing data; many of these limitations remained in 2016.

Data collection continues to be a challenge due to the nature of the health care system and the individual organizations collecting data. Parts of the system are oriented toward documenting outputs (e.g., number of HIV tests) rather than outcomes (e.g., a positive or negative HIV test result) because often billing and reimbursement, not public health, was the primary concern driving their design. Data sharing issues and lags in data reporting contribute to challenges in ensuring data are standardized, accurate, and complete.

Data limitations also stem from cross-agency (and, in many cases, cross-program and cross-grantee) variance in 1) the definitions applied to primary data elements, and 2) the independence of the systems used to manage and generate these data. In particular, two data points, "number of tests" and "number of new positives," exemplify both these limitations and their ramifications for measuring the cumulative impact of federally-funded HIV testing activities. Some agencies reported the total number of HIV

tests[7] conducted, while others reported the number of test events.[8] Similarly, among those agencies that reported the number of persons with HIV newly diagnosed through their programs, some relied entirely on client self-reports of not having a previously diagnosed HIV infection, while others confirmed such reports with HIV surveillance data collected by health departments. Further, because federal agencies do not collect, maintain, or share personally identifiable information (e.g., the names and birthdates of persons who test positive for HIV), matching and avoiding duplication of data across systems at the federal level is not possible.

Barriers to Achieve Optimal Levels of Testing

While the annual testing goal of five million tests was again surpassed in 2016, contributing federal organizations continue to experience barriers to achieving even higher levels of HIV testing and, specifically, identifying persons with undiagnosed HIV. Federal agencies identified barriers encountered by agencies, grantees, and testing providers, including data collection and coordination, funding, staffing, and policies.

- *Data Collection* -- Many agencies, grantees, and providers have challenges collecting and reporting data. These issues are generally related to the following:
    - **Training**: Agencies are challenged by lack of staff knowledge of data management in both storing and analyzing data collected.
    - **Data collection tools and software:** Agency data infrastructure often does not fully support efficient use of Electronic Health Records (EHR).

[7] Preliminary and confirmatory HIV tests were counted independently. Accordingly, when an individual whose preliminary test was positive received a confirmatory test, his or her two tests would both be counted towards the total number of tests reported.

[8] A testing event could include up to three tests for a given individual when these tests were conducted as part of a single testing episode. For example, person who tests positive on a preliminary HIV test and so receives a confirmatory test would be captured as one testing event.

- **Coordinating across large and disperse facilities:** Some agencies have regional facilities that use private sector EHR platforms that are not linked to the public EHR platform.

- *Funding* -- For some agencies, limited and uncertain funding challenges their ability to design and implement high-impact HIV prevention strategies.
  - **No base funding:** Some agencies receive no base funding for HIV-related activities and are dependent on annual proposals to Minority HIV/AIDS Fund to support their testing efforts.
- *Staffing* -- High rates of staff turnover for grantees, hiring freezes, and limited access to quality training can delay program implementation and reduce effectiveness of testing activities.
  - **Staff Turnover and New Staff**: Constantly educating and training a high proportion of new staff slows down program implementation.
  - **Hiring Freezes**: Some states implement hiring freezes that even apply to federally granted funds.
- *Laws, Regulations, and Organizational Policies* - Several organizations expressed the need for clarification on various HIV testing policies and regulations.
  - **Limited knowledge of existing regulations:** Some agencies were unaware of what regulations were in place surrounding rapid testing without laboratory technicians.
  - **Difficulty instituting programs given existing laws:** Some grantee programs found it difficult to institute an opt-out testing model as several states require written informed consent for HIV testing.

Cost Estimate to Conduct Five Million Tests

CDC estimated the median cost of reaching the annual goal of conducting 5 million HIV tests was $1.24 billion (range: $0.62B to $1.86B) in 2017. Federal organizations published costs and cost data from

evaluation studies of HIV testing programs. These data vary substantially based on testing settings, testing strategies, testing technologies, inclusion or exclusion of linkage to care, assumptions, and costing methods. Based on the range of cost estimates available in the literature and their relative alignment with the range of figures reported by federal agencies for this report, CDC used a potential median cost of $80 per test in clinical settings and $750 per test ($US 2017) in non-clinical settings to arrive at a cost estimate (Shrestha *et al.* 2008, 2011, 2012). To estimate the lower and upper bounds for the federal funding needed to meet the annual testing goal, CDC then varied the median cost estimates by 50 percent in either direction.

Cost-Effectiveness of HIV Testing

The previous Testing Report to Congress described CDC's systematic review of the cost-effectiveness literature relevant to HIV testing and, where possible, compared the costs and effects of different HIV testing. The literature used several cost-effectiveness measures: cost per quality adjusted life year (QALY) saved, cost per life year (LY) saved, cost per HIV infection averted, and cost per new HIV diagnosis identified. Variation across studies limited CDC's ability to directly compare results across different testing approaches or implementation settings. Additional details can be found on pages 29-37 in the previous report.

The value to the nation of attaining the goal of conducting 5 million HIV tests will, however, far outweigh the initial federal investment needed to meet it. A review of the literature continues to show that voluntary HIV testing is cost-effective, and potentially even cost saving,[9] across a wide range of implementation scenarios and settings (Lin *et al.*, 2016; Hutchinson *et al.*, 2016; Schackman *et al.*, 2015; Farnham *et al.*, 2012; Lucas and Armbruster, 2012; Long *et al.*, 2010; Paltiel *et al.*, 2006; Paltiel *et al.*, 2005; Sanders *et al.*, 2005; Walensky *et al.*, 2005). CDC identified one published study that

[9] "Cost-saving" indicates that the money spent to deliver the service was less than the money saved by avoiding downstream costs (e.g., the lifetime treatment costs associated with those HIV infections that would have otherwise have been acquired).

estimated the return on investment (ROI) associated with CDC's own Expanded Testing Initiative (ETI) to be $1.95 back to the health care system as a whole, for each dollar invested. When disregarding the downstream treatment costs associated with earlier awareness of HIV infection, the ROI rose to $11.43. Since many medical interventions have negative (i.e., less than $1) ROIs (Trogdon *et al.*, 2009), these findings suggest that large scale, HIV testing programs like CDC's ETI yielded strong economic and public health returns (Hutchinson *et al.*, 2012).

Conclusion

Federal agencies will continue to play an important role in ensuring that HIV testing services are available to those individuals not optimally reached through the private sector. As part of the *Ending the HIV Epidemic: A Plan for America* initiative, CDC will work closely with other HHS agencies, local, and state governments, communities, and people with HIV to coordinate efforts to increase capacity to test for and diagnose all people with HIV as early as possible. Agencies will also continue to explore better ways to assist states, health care providers, community based organizations (CBOs), and other funded entities to address the challenges and barriers they encounter when providing HIV testing services. Although federally supported HIV prevention, care, and treatment programs have substantially exceeded the annual national HIV testing goal, there is still more work to be done to increase the proportion of persons whose infections are diagnosed, and where possible, diagnose them early. Federal agencies continue to be committed to focusing efforts on increased HIV testing as a bridge to improved health and well-being of individuals with HIV and in the communities in which they live.

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Appendix 1:
2013-2016 Tables

Table 1. Number of HIV Tests Conducted by Federal Agencies in 2013

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,352,513	29,003	0.87%	21,712	74.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,331,210	DNC[e]	UA[f]	DNC	UA
Medicare	262,321	DNC	UA	DNC	UA
Health Resources and Services Administration (HRSA)					
HAB[g]	787,663	8,654	1.10%	7,774	89.83%
BPHC[h]	1,188,651	DNC	UA	DNC	UA
Indian Health Service (IHS)					
IHS/Tribal/Urban	51,535	87	0.17%	6	6.90%
Office of Population Affairs (OPA)					
Routine Services -95 Title X Service Grantees & Independent Grant Awards	1,371,181	2,121	0.15%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	39,519	DNC	UA	DNC	UA
CSAT TCE[j]	16,607	184	1.11%	112	60.87%
Department of Veterans Affairs (VA)					
	505,830	1,793	0.35%	DNC	UA
Total Number of Tests: 9,817,020					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2010 is presented in the 2013 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services."

Table 2. Number of HIV Tests Conducted by Federal Agencies in 2014

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,198,430	28,420	0.89%	21,843	76.86%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	2,403,423	DNC[e]	UA[f]	DNC	UA
Medicare	219,948	DNC	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	58,076	322	0.55%	319	99.07%
Health Resources and Services Administration (HRSA)					
HAB[g]	802,440	7,575	0.94%	6,798	89.74%
BPHC[h]	1,322,317	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	96,602	111	0.11%	DNC	UA
Office of Population Affairs (OPA)					
	1,031,624	2,112	0.20%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	17,426	DNC	UA	DNC	UA
CSAT TCE[j]	10,530	81	0.77%	DNC	UA
Department of Veterans Affairs (VA)					
	319,999	665	0.21%	DNC	UA
Total Number of Tests: 9,480,815					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Medicaid data from 2012 is presented in the 2014 testing table as it was the data most recently available from CMS
e. Agency does not collect (DNC) this data.
f. Data are unavailable (UA).
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services.

Table 3. Number of HIV Tests Conducted by Federal Agencies in 2015

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,038,074	27,729	0.91%	22,906	82.61%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	237,244	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,420	293	0.48%	291	99.32%
Health Resources and Services Administration (HRSA)					
HAB[g]	652,207	7,009	1.07%	5,936	84.69%
BPHC[h]	1,447,628	DNC	UA	DNC	DNC
Indian Health Service (IHS)					
	91,464	112	0.12%	DNC	DNC
Office of Population Affairs (OPA)					
	1,113,635	2,423	0.22%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	27,731	256	0.92%	199	77.73%
CSAT TCE[j]	8,892	57	0.64%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	4,575	31	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,635	488	0.18%	DNC	UA
Total Number of Tests: 6,953,505					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers.

Table 4. Number of HIV Tests Conducted by Federal Agencies in 2016

Federal Agency	Number of Tests	Number Positive[a]	Percent Positive[b]	Number Referred to Care	Percent Referred to Care[c]
Centers for Disease Control and Prevention (CDC)					
Health Departments and CBOs	3,035,128	27,373	0.90%	21,451	78.36%
Centers for Medicare and Medicaid Services (CMS)					
Medicaid[d]	UA[e]	UA	UA	UA	UA
Medicare	236,571	DNC[f]	UA	DNC	UA
Department of Justice/ Federal Bureau of Prisons (DOJ/FBOP)					
	61,671	203	0.33%	203	100%
Health Resources and Services Administration (HRSA)					
HAB[g]	563,400	5,826	1.03%	5,118	87.85%
BPHC[h]	1,612,535	DNC	UA	DNC	UA
Indian Health Service (IHS)					
	85,772	131	0.15%	DNC	UA
Office of Population Affairs (OPA)					
	1,163,883	2,824	0.24%	DNC	UA
Substance Abuse and Mental Health Services Administration (SAMHSA)					
CSAP MAI[i]	23,280	189	0.81%	DNC	UA
CSAT TCE[j]	9,475	49	0.52%	DNC	UA
CMHS/CSAP/CSAT - MAI-CoC[k]	7,452	51	0.68%	DNC	UA
Department of Veterans Affairs (VA)					
	270,575	476	0.18%	DNC	UA
Total Number of Tests: 7,069,742					

a. Several agencies reported the total number of persons with HIV cared for or registered in their system within a given year. This data was omitted from the tables as it is not reflective of the total number of persons with a positive HIV diagnosis that is derived from the number of tests conducted within the specified year.
b. (Number of Positive Tests/Number of Tests) x 100.
c. (Number of Persons with HIV Referred to Care/Number of Positive Persons) x 100.
d. Most recent Medicaid data is from 2012 and is reported in Table 2
e. Data are unavailable (UA).
f. Agency does not collect (DNC) this data.
g. HIV/AIDS Bureau.
h. Bureau of Primary Health Care
i. Center for Substance Abuse Prevention (CSAP), Minority AIDS Initiative (MAI)
j. Center for Substance Abuse Treatment (CSAT), "Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services
k. Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) Minority AIDS Initiative (MAI), Continuum of Care (CoC). This program is jointly funded by all three SAMHSA Centers

VAExecSec

Sent: Monday, August 19, 2019 4:21 PM
To: VHA CO 10B1 Correspondence Mgmt. Staff; VHA CO 10B1 Review Staff
Cc: (b)(6); McVicker, Carrie A.; (b)(6)
Subject: FW: Intergovernmental Transfer - Appeal for Resolution
Attachments: Monday, April 08th, 2019 (b)(6) docx; March 2019 Written Warning Package.pdf; VA Hosptial Timelime for Assistance.docx; (b)(6) Thursday, August 15th, 2019.docx; July 25th Email Conversation.docx; EXAMPLES OF RECOGNITION DATA MINAPULATION. FALSE, ETC..docx

From: Executive Secretariat <m-Executive.Secretaria@dol.gov>
Sent: Thursday, August 15, 2019 12:39 PM
To: VAExecSec <VAExecSec@va.gov>
Subject: [EXTERNAL] Intergovernmental Transfer - Appeal for Resolution

TRANSFER

To:

U.S. Department of Veterans Affairs
Office of the Executive Secretariat
810 Vermont Ave., NW, Room 1027
Washington, DC 20420

RE: (b)(6)

The U.S. Department of Labor, Office of the Executive Secretariat, is referring the attached correspondence to your office for appropriate handling. This correspondence was either misdirected, or the subject matter falls within your jurisdiction.

Sincerely,

Office of the Executive Secretariat
VHA – please

From: (b)(6) @sc.rr.com <(b)(6) @sc.rr.com>
Sent: Thursday, August 15, 2019 7:41 AM
To: (b)(6) @governor.sc.gov' (b)(6) @governor.sc.gov>; 'information@admin.sc.gov' <information@admin.sc.gov>; 'ofo.eeoc@eeoc.gov' <ofo.eeoc@eeoc.gov>; Webmaster DOL <webmaster.dol@dol.gov>; (b)(6) - OASAM CRC <(b)(6) @dol.gov> (b)(6) @governor.sc.gov (b)(6) @governor.sc.gov>; 'inspectorgeneral@eeoc.gov' <inspectorgeneral@eeoc.gov>; Executive Secretariat <m-Executive.Secretaria@dol.gov>; (b)(6) @scott.senate.gov' (b)(6) f@scott.senate.gov>
Subject: Appeal for Resolution (b)(6)

Good morning,

Please see attached correspondence and previously submitted information. Again, I appeal to you for assistance in complete resolution.

Thank you very much for your time.

God's Blessings to each of you.

April 8th, 2019

(b)(6)

You are certainly welcome. I too thank you and Jim for your time and the opportunity to speak with you. I realize your schedules are very busy.

I am responding to your Follow up, regarding:

1. I am in partial agreement. However, I asked about key contacts that fall with my direct responsibility. Not knowing are being kept in the loop can adversely impact ones EPMs, job decisions and supervision of staff. Often it sends a contradicting message to staff and sometimes supervisors that they don't have to operate within the chain of command.
2. Respectfully, the response on many levels was insulting. The statements were false and presented in a factual manner. Please see below.
3. Respectfully, I do disagree and felt that your response to me on March 12th, 2019 did not promote a satisfactory or harmonious work environment. Primarily, the false statements and sarcastic manner. Additionally, I felt like the false statement encompassed: Misrepresentation of Facts, Improper Conduct or Conduct Unbecoming a State Employee and Willful False Statements.

My simple request was to have these statements retracted. While, I am very much appreciative of an apology it does not correct and or set the record straight. To be falsely accused is a very unpleasant and unjust feeling. It establishes an unfavorable picture of work ethics.

Respectfully, the underlined statements are stated as factual. There is no ambiguity. There is nothing to be misconstrued, misunderstood or misinterpret. The underlined statements are concise, well-defined and directly links adverse work behavior that mischaracterizes my overall work ethics. I can say with 100% percent of certainty that all underlined statements below are false and the attempt to link and show me as an employee that does not answer my phone or return calls/messages is a complete fallacy. And being a complete fallacy it does not in any way support the theory that I am misinformed because I do not do these things. It is primarily due to what is conveyed in Item 1 above.

The call was regarding the following.

In my March 08, 2019, in an email, I asked, "Can you please share with me the reason I am being overlooked when it comes to requesting or providing instructions to staff in Region 1. I provided 5 examples. I ended the email with, "please tell me if there is something I need to know. It is becoming increasingly odd to be informed by supervisors of instructions/information given directly to them, leaving them often asking me, "Did you know this?"

(1). You responded in March 12, 2019 email, "If you would speak to your supervisor and the other RDs", you would know that it is not unusual for me to reach out directly to the person who I need to communicate (including worker). In an email to Ms. My Response: via email dated March 12th, 2019, I requested specifics to show how this has bearing on what I asked in the email. In March 13th, 2019 email I asked for facts that the statement was based upon. I speak and have conversations with Jim Hampton, Mark Scanlan and Terrence Foulks. I conveyed "the statement was not true and damages my character."

(2). You responded in March 12th, email, Also, I am aware of at least two occasions in the past three weeks where one of your Supervisors has attempted to reach you by telephone to give you preliminary

information on some of the issues you mention. However, you failed to answer your phone or return the calls. My Response: Regarding (2) and (3), via email dated March 12th, 2019 I conveyed that I completely disagree with your statement. I asked how this information was reported to you. I respectfully requested specifics date and time. In March 13th, 2019 email, I conveyed, "The only time I do not answer my phone is when I am unable to do so." I am requesting specifics regarding this statement and how did awareness come about? I conveyed that I had a right to know since it was being presented as an adverse behavior. So still as of today, I am requesting the date, time and the name of the supervisor(s) that attempted to call me in the past three weeks that I failed to answer or return their call and specifically what preliminary issues that I mentioned that this supervisors was calling to give me? How did the information come about? If so, how was the reason for me not answering the alleged calls identified and verified?

(3). You, responded March 12th, 2019 email, "Going forward, I recommend that your either answer a phone call from your Supervisors and/or return your Supervisors messages promptly. This will allow you to remain informed. My Response: In email dated March 12th, I added, like everyone that has a phone or and just as I pulled over to a parking space to answer a call, there are time when I am unable to answer the phone and I call back later or respond via email. If you leave me a message or email, I call or make contact with you. I could be out of the office, on a call, in a meeting or on the road driving or on sick/annual leave. I am no different from those that report to me, peers and those that I report too whom have not answered their phone for various reasons. In an email dated March 13th, 2019, I added, "out of 2 alleged calls, I would like to know if a record has been kept on all over 1,000 of calls that I have return. Again, I am requesting facts to validate that I fail to answer phone call from my supervisor and/or return supervisors' messages promptly

I ended the March 13th, 2019, "as my right, I am requesting facts on all these statements or they be retracted. Again, the tone of the response was so attack mode and not true. These was nothing mean-spirited or unprofessional regarding my email. I simply asked questions. Thank you.

Additionally Regarding the Email:

Respectfully, I stand behind the bully and slanderous statement as this is what I immediately and distinctly felt and still do today. Please see below:

Bully: Mistreatment of someone of a lower stature by someone, more powerful, etc., the actions and behavior. To treat someone in a cruel or insulting fashion resulting in fear. A repeat treatment.
• "If you would speak to your supervisor and the other RDs • Also, I am aware of at least two occasions in the past three weeks where one of your Supervisors has attempted to reach you by telephone to give you preliminary information on some of the issues you mention. However, you failed to answer your phone or return the calls. • "Going forward, I recommend that you either answer a phone call from your Supervisors and/or return your Supervisors messages promptly. This will allow you to remain informed.
The above first four statements are false. To be a recipient of four false statements so openly from a superior conjures up immediate fear for job, work reputation, disciplinary, etc. I did feel very insulted and it was cruel. The last bullet, I am literally being chastise based on false information. The fact that someone or you would become aware of adverse information and not allow me the opportunity to respond before making it a factual statement is mistreatment and unfairness on my behalf. Bullet 1 and 3 are with sarcasm, defensive and condescending. Bullet two is received as defensive. There is a

fundamental difference between the words "fail" and "unable". When you "fail": not do something; leave something undone. It is negative. If you are "unable" for whatever reason you are just not able to do. If I miss a call or it take time to return a call or message it is because I am unable to do so with a valid reason. False statements do not validate, support or illustrate the point of being misinformed.

Slander: Making false statements damaging to a person reputation; misrepresentation of character.
• "If you would speak to your supervisor and the other RDs • Also, I am aware of at least two occasions in the past three weeks where one of your Supervisors has attempted to reach you by telephone to give you preliminary information on some of the issues you mention. However, you failed to answer your phone or return the calls. • "Going forward, I recommend that you either answer a phone call from your Supervisors and/or return your Supervisors messages promptly. This will allow you to remain informed.
All statements above are false and depicts detrimental work habits that I do not possess. It is a malevolent mischaracterization of work ethics that has the potential of doing greater harm and to be use adversely against me in the future. Again, Bullet 1 and 3 are with sarcasm, defensive and condescending. Bullet two is received as defensive. There is a fundamental difference between the words "fail" and "unable". When you "fail": not do something; leave something undone. It is negative. If you are "unable" for whatever reason you are just not able to do. If I miss a call or it take time to return a call or message it is because I am unable to do so with a valid reason. False statements do not validate, support or illustrate the point of being misinformed.

My Perspective:

Respectfully, as I have previously conveyed. It seems that as it relates to me, there appears to the strategy to show me as in the wrong on a grand scale. There have been several examples shared. I received a disciplinary documents with false information, cited for a HR Manager II doing their job and told, in doing so told I allowed the action. I was made to sign a blank 114 HR Personnel transaction form in July 2016 just days after my refusal to sign the Written Reprimand in the same month. Had a TSA was taken way retroactively, while still performing the job and no break in service. In 2017, I received the worst evaluation, I ever received in my entire career, with reference to just general conversations. I was cited because I could not make the connection between an individual with two different names. In 2017 was told I was the reason for EEMS not reaching 100% completion, after making efforts to resolve and ensure all EPMS were due before going on vacation. And then having to use much of this time for bereavement due to the death of close family member. Received a second written warning for mistakenly thinking the Division had its own policy on this. Only days later for the Agency to send out such a Policy. Months later the Deputy informed supervisors on a call that for staff working outside and not turn in their Outside Employment form, to do so they were not going to get in trouble and will receive full amnesty. The Agency has a clear policy on Outside Employment. Not even realizing

who these staff were they and their prior history, they were given full amnesty. My point, I am certainly not against providing staff the amnesty. The point is being fair to everyone. And the case of false and/or manipulative data.

I am very private person and I have worked very hard for the past 30 plus years. I work very hard to promote an environment for staff that is transparent, show fairness and be productive. In my over 30 years, I have never witness an employee treated the manner in which I continue to be treated. I am polite and nice, but yet very effective in my job. I don't strive to be that way that is who I am. I have experience enough traumatic events in my life to not inflict or support adverse or unfair actions on anyone. And, yet I feel like it never stops. I feel like if I cough in a meeting, I will be written up for failure to maintain a harmonious work environment. And that is truth. I feel like every day, I am up against trying to maintain my dignity and not bend my back. I will maintain my dignity.

Again, thank you both for your time.

February 24, 2019

To:

The Honorable Governor Henry McMaster, Governor of South Carolina
The Honorable Pamela Evette, Lieutenant Governor of South Carolina
The Honorable Lindsey Graham, Senator for South Carolina
The Honorable Tim Scott, Senator for South Carolina
The Honorable James Clyburn, Congressman for South Carolina
Mr. (b)(6) Chief of Staff for the Governor of South Carolina
Mr. (b)(6) eputy Chief of Staff for the Governor of South Carolina
Mr. (b)(6) mbudsman for the Honorable Senator Tim Scott
Mr. , Ombudsman for the Honorable Senator Lindsey Graham
Ms. Press Secretary for the Honorable Representative James Clyburn

On February 19th, 2019, I sent an email regarding data manipulation and falsification. Within that email I also expressed concern regarding the VA Hospital reaching out to DHHS for assistance with moving along pending Medicaid applications, in addition a phone call-in process for Long Term Care families visiting county offices.

Unlike with the data, I did not provide information to illustrate my concern regarding the Veteran matter. I remain deeply concern by the multiple request that the VA Hospital made for assistance. **On August 09th, 2018 at 8:54 am**, I received an email from the Chief of Social Work at the Dorn VA Medical Center. The email stated in part, *"as a hospital we are under high demand once the veteran is medical stable and placement is located to discharge in the community. It is now taking 7-9 months before a Medicaid application is process and approval obtained. We desperately need an outstation worker to streamline the process."* **On August 09, 2018 at 9:40 am**, I responded to the VA Chief of Social Work via email: *I do appreciate your interest in the Outstationed Worker Program (OSW). Please allow me to have some internal discussions regarding your request. I am scheduled to be out of the office August 10th and 13th. I will make contact with you upon my return. Again, thank you for the inquiry and the service you provide to our veterans. Have a wonderful weekend.*

Upon my return, on **August 14th, 2018**, via email, I notified the DHHS Director of LTC about the VA Hospital request and informed her that I was going to have a follow-up call with the VA Chief of Social Work on Thursday of that week. On **August 15th, 2018**, The DHHS LTC Director respond via email, that it was her understanding the agency did not intend to add outstationed workers. I made the LTC Director aware that the placement of a worker at an outstationed site is something that we could look at on an individual need. The LTC Director indicated that she would like to have a better idea of their onsite need and referenced prior discussions pertaining to outstationed sites, to include would an admin type worker on site to take and scan applications and answer basic questions be of any benefits to the VA Hospital. The DHHS LTC Director, conveyed that she would be happy to have a conversation with them.

I spoke with the VA Chief of Social Work upon my return, that week and she thanked me via email on August 20th, for reaching out to her. On **August 21st, 2018**, I emailed the VA Chief of Social Work with a copy to the DHHS LTC Director. In the email, I provide her with the name of the DHHS LTC Director and informed her that LTC Director oversee the Long Term Care Program and would like to have a conversation with her regarding her request and the process. I thanked the VA Chief of Social Work for the information provided and wished her a wonderful day.

On October 19th, 2018, (about 2 months later), I was copied on an email from the VA Chief of Social Work to the DHHS LTC Director. The VA Chief of Social Work, indicated:" *we had a conference call on **9.4.18** to discuss how the Dorn VAMC could proceed with obtaining an Out-Stationed Worker on site at the medical facility. You explained during the call that it would be unlikely for us to move forward with the OSW Program at the VA as it was being phased out but you did agree to explore other options. I have not received feedback as of this date and continue to struggle with obtaining consistent information on pending Medicaid applications for Veterans hospitalized on the acute medical units that are essentially waiting on approval for placement. I will be glad to coordinate another call if needed and look forward to hearing back from you".* I oversee the OSW Program and no has informed me the program is being phased out. I have even inquired and received no response

On November 09, 2018 (about three months later), I was copied on another email from the VA Chief of Social Work to the DHHS LTC Director. In the email again, she indicated, *"I have not hear back from you and would really like to follow-up and explore options as we discussed on 9.4.19. Please advise."*

On November 12th, 2018(over 3 months later), I was copied on the response from the DHHS LTC Director to the VA Chief of Social Worker. The DHHS LTC Director *apologized for the delay and informed the VA that they would be able to use the Nursing Home Provide Liaison Center. That someone from BCBS , the contractor who runs the NHPLC would be reaching out to set up a call and provide guidance on how the inquired could be made.*

On January 03, 2019, 4:34 pm (6 months later), I was copied on email from another employee of the VA Hospital to the DHHS LTC Director requesting a time to receive some training. *She indicated the Chief of Social Work would be on leave until the next week but that she was available. That same day, on* **January 3, 2019 at 4:51 pm**, the DHHS LTC Director responded, *"what type of training are your requesting?"*

On January 04, 2019, 7:35 am.(6 months later), the VA Rep. responded, *"the training for the Nursing Home Provider Liaison Center in the email below. We haven't received instructions on how to access it.* **January 4, 2019, 8: 18 am**, the DHHS LTC Director responded, *"I was not aware that they had not reached out to you. I have a call with them today and will see what is going on."*

On January 09, 2019, 9:28 am, the VA Rep. again email the DHHS LTC Director and asked, *"Were you able to get information? Can we start to access them?"* **January 09, 2019, 1:31 pm**, the DHHS LTC Director responded via email, *"You should hear from the Liaison Center if you haven't already with instructions. I spoke to them the other day. Based on our conversation they had reached out to the Chief of Social Work back when this was first discussed but had not heard back.* **January 09, 2019, 8:46 pm,** the VA Chief of Social Work responded, *"Thank you for following up. I honestly don't recall being contacted as of this date but have been out of the office throughout the Holiday so it's possible an attempt was made. If we didn't receive a telephone call from the Liaison Center is there a contact number for us to reach out to them?*

The initial request for assistance with Medicaid applications from the VA for veterans was made in **August 2018.** During that time according to the VA Chief of Social Work they were behind 7-9 months with applications. Based on the emails that I were copied on in January 2019 the process still had not been finalized. Factoring together the 7-9 months and the five months from August 2018 to January 2019, that would be approximately a year of possible delayed service. Also, the VA Chief of Social Work conveyed on August 20th, 2018 that the average number of Medicaid applications per month was 15-20.

In an email, February 7, 2019, to the EEMS Deputy Director, etc. I mentioned that *I would be remiss, if I did not make known that I hope the process that is in place address the VA Dorn Hospital application is working. I could not think of a more deserving population than the men and women who served our county and vowed to protect us all.*

I cannot sit by and not say anything on behalf of our veterans. Deserving men and women that are now in need of medical care from their home state. The thought of an Agency that is in a positon to assist in this most critical area, not doing so or delaying that service is simply unthinkable and extremely disheartening. Our Veterans battle illnesses from forms of cancer, depression, paralysis, limb loss, loss of sight and hearing, burns, etc. They deserve better.

My plea to you again as I did February 19th, 2019. I have worked in this line of work for over 30 years with DSS and DHHS and I have never seen what appear to be a lack of empathy and disconnect from the community. To again include the LTC phone system in the county offices. This email is not sent to single anyone out. I have conveyed this more than once. This is not my purpose. I don't get any form of satisfaction from these type actions. Simply Some guidance is needed.

Yet, for myself, I still await a response to the emails that I have sent. I will continue to send my certified packages to the US and South Carolina Congress and Civil Rights groups. I had place some of this behind me. . I was instructed to target another female to fire. When I refused, I became the subject of the same type of targeting. I was told to my face that I was inferior to a male based on driving abilities, had my income take away retroactively, while giving the men more income and for public humiliation made to report to my peer. The only one doing so in EEMS. I was literally written up, signed by the EEMS Deputy Director and HR Director II for following the HR Referral process that managers follow even as of today statewide in state government and the private sector. That is where there is a HR matter report it to the HR Manager. Which I did and the HR Manager made a decision based on HR policy and took the action. Literally the HR Manager II literally made the call to convey the decision and I received the written warning and told I should not have allowed the HR Manager to make a call. I have never heard such thing before in State Government. The written warning even contained a false statement regarding the orientation date of a supervisor. Then the written warning contradicted itself, saying at one point I solely make a decision and then again it stated I should gotten advice. They turned around and wrote me up again, for a 1. 75 (2) toll ticket that I was of the understanding, we had the option to have toll paid out of an Agency Account. Afterwards the Agency sent out a DHHS State Vehicle Policy, to clarify this for employees. Next, followed by an announcement on a supervisor call that employees who violated the Outside Employment Policy were to just turn in their completed form and receive full amnesty. Even took the time on the call to provide clarification to staff. This action alone negates any form of disciplinary action administered. I am requesting these be nulled and voided as it clearly shows a disparate treatment. I feel the treatment remains today and there is an effort to continue to take away job functions and county staffing from under my supervision. The Agency is being allowed to victimize me for being a victim, who attempted to do right. I will continue to be professional, cordial and do my job. I believe justice will prevail. I will continue to share my story until it is.

Thank you.